INDIANA BOARD OF PHARMACY

INSTRUCTIONS FOR CERTIFICATION AS A PHARMACY TECHNICIAN (CPT)

INSTRUCTIONS AND INFORMATION

Before completing and submitting your application to the Health Professions Bureau, please read all instructions and information included with this packet. If you have any questions, please contact the Board of Pharmacy at (317) 234-2067 or hpb4@hpb.IN.gov.

You cannot legally work in a pharmacy as a technician unless you have received your technician-in-training permit or your technician certification from the State of Indiana.

BUREAU ADDRESS

Indiana Board of Pharmacy
Health Professions Bureau
402 West Washington Street, Room W066
Indianapolis, IN 46204

THE FAIR INFORMATION PRACTICE ACT

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record. Your examination scores and grade transcripts are confidential except in circumstances where their release is required by law, in which case you will be notified.

Your Social Security Number is being requested by the state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

CERTIFICATION AS A PHARMACY TECHNICIAN (CPT)

PLEASE NOTE THE FOLLOWING:

Individuals may qualify to be certified as a Pharmacy Technician in two ways:

1. **APPLICATION BY EXAMINATION:** If an individual has passed the PTCB examination. Along with an application, an individual must also submit a copy of their PTCB certificate as proof of successfully completion of the exam.

2. **APPLICATION BY BOARD APPROVED TRAINING AND EDUCATION:** If an individual has completed a Board-approved program of training and education. Along with an application, an individual must also submit one of the following:
    a. Certificate of Completion from Board Approved Program, or
    b. Education/Training Affidavit—This form must be signed by the current Qualifying Pharmacist of the pharmacy at which the program was completed.

IMPORTANT INFORMATION

- The initial application fee is $25.00. The renewal fee is $25.00.

- The certification will expire June 30 of even-numbered years.

- This certification does not change the practice of pharmacy technicians. The only change is that they are now regulated by and accountable to the Indiana Board of Pharmacy.

- The easiest and most efficient method of application is online. Since July 1, 2003, the Indiana Board of Pharmacy has accepted online applications via our website at the following address: www.in.gov/hpb/boards/isbp/index.html. Step-by-step instructions for applying online are available on the website. You can complete an application and pay the $25.00 application fee with a VISA or MasterCard (credit or debit card) in a few easy steps. You must then submit the required supporting documentation (education and training affidavit or certificate or PTCB certificate) to the Board at 402 West Washington Street, Room W066 Indianapolis, IN 46204.

APPLICATION INSTRUCTIONS

Technician certification applicants must submit the following:

- Completed application with a $25.00 application fee.

- If you answered "yes" to any questions on page 2 of your application, explain fully, including all related details in a signed and notarized statement. Include the violation, location, date, and disposition.

- If you have completed a training and education program, then you are required to submit either a copy of the certificate of completion or the enclosed affidavit of completion. If you have completed the PTCB examination, then you are required to submit a copy of your PTCB certificate. If you have not completed either of these requirements, you will need to apply for a technician-in-training permit.

- A notarized copy of a marriage certificate or an official affidavit indicating any legal name change, if your name differs from that on any documents.

TECHNICIAN-IN-TRAINING INFORMATION

If you have not yet completed a training and education program, or do not yet have your PTCB certificate, then you will need to apply to be a technician-in-training. Technician-in-training applicants must submit the following:

- Completed application with a $25.00 application fee.

- If you answered "yes" to any questions on page 2 of your application, explain fully, including all related details in a signed and notarized statement. Include the violation, location, date, and disposition.

- Your technician-in-training permit is valid for up to one year from the date of issuance. This should give you an ample amount of time to either complete your training and education program or your PTCB. Once you complete the training and education program or the PTCB, you will then be required to submit proof of completion. ***You will not need to submit a new application and $25.00 application fee with this documentation.***

INDIANA BOARD OF PHARMACY

APPLICATION FOR CERTIFICATION AS A PHARMACY TECHNICIAN (CPT)

FOR OFFICE USE ONLY

Application/Permit Fee:
Date Fee Paid:
Receipt Number:
License Number Issued:
Permit Number Issued:
Date License Issued:

Please check all that apply:

_____ I have completed a program of education and training approved by the Board. (Please include verification of completion of the program and/or training)

_____ I have passed a certification examination offered by a nationally recognized certification body, approved by the Board. (Please include a copy of your certificate)

If you did not check at least one of the above, you must apply for a Pharmacy Technician-in-Training Permit

I am applying for a Pharmacy Technician-in-Training Permit: YES _____ NO _____

NAME: _____

(Last) (First) (Middle) (Maiden or Previous)

CURRENT ADDRESS: _____

(Street Number or Rural Route)

_____

(City) (State) (Zip Code)

_____

PERMANENT ADDRESS (IF DIFFERENT FROM ADDRESS ABOVE)

_____

(City) (State) (Zip Code)

WORK NUMBER: _____ **HOME NUMBER:** _____

(Include Area Code) (Include Area Code)

EMAIL: _____

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____

(Month/Day/Year) (City & State)

SOCIAL SECURITY NUMBER (Required):_____

If your answer is "yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1.) Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? ____ YES ____ NO

2.) Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country? ____ YES ____ NO

3.) Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? ____ YES ____ NO

4.) Have you ever been convicted of, pled guilty or nolo contendre to, or are formal charges pending for:
(A) a violation of a Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances? ____ YES ____ NO
(B) any offense, misdemeanor or felony in any state? (except for minor violations of traffic laws resulting in fines) ____ YES ____ NO

5.) Have you ever been denied employment in a pharmacy, or had such employment revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations? ____ YES ____ NO

6.) Have you ever had a malpractice judgement against you or settled any malpractice action? ____ YES ____ NO

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that disclosure of your U.S. Social Security number on your application is mandatory for the purpose of complying with IC 25-1-5-8 and IC 4-1-8-1 which provide that the Indiana Department of Revenue may obtain Social Security numbers from the Health Professions Bureau for tax enforcement purposes. In addition, disclosing such number is mandatory in order for the licensing board or committee to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank 42 U.S.C. §1320(a)-7e(b), 5 USC §552a, 45 CFR Part 60.1, and 45 CFR Part 61.

Failure to disclose your U.S. social security number will result in the denial of your application. Application fees are not refundable.

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

_____ _____

Signature of the Applicant **Date signed (month, day, year)**

AUTHORIZATION FOR RELASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization, or institution to release to the Health Professions Bureau of Indiana, or the Indiana Board of Pharmacy, any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana, or the Indiana Board of Pharmacy, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information, which is material to my application, and I hereby specifically release the Bureau, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

_____ _____

Signature of the Applicant **Date signed (month, day, year)**

AFFIDAVIT OF COMPLETION OF PHARMACY TECHNICIAN EDUCATION/TRAINING PROGRAM

Health Professions Bureau
Indiana Board of Pharmacy
402 West Washington Street, Room W066
Indianapolis, Indiana 46204
317-234-2067
http://www.in.gov/hpb/boards/isbp/index.html

I, _____, do solemnly swear or affirm under the
(Name of Qualifying Pharmacist)

penalties of perjury, that _____ has completed the
(Name of Pharmacy Technician)

following Board approved program of education or training:

_____
(Name of Indiana Board of Pharmacy Approved Program)

_____
Signature of Qualifying Pharmacist

_____
Date

_____
Signature of Pharmacy Technician

_____
Date